PIECES

National Multi-disciplinary Child Death Review in the EU:

PIECES Policy Paper #5

EUROPEAN CHILD SAFETY ALLIANCE

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Introduction

The Committee for the Rights of the Child General Comment No. 13 in 2011 recognised that measures to end child violence must be massively strengthened and expanded in order to effectively deal with the pervasive problem. The document highlights the governmental obligations to establish policies, programmes, monitoring and oversight systems required to protect the child from all forms of violence. This includes, for example 'Establishing a comprehensive and reliable national data collection system in order to ensure systematic monitoring and evaluation of systems (impact analyses), services, programmes and outcomes based on indicators aligned with universal standards, and adjusted for and guided by locally established goals and objectives at the national and sub-national government levels' (UN, 2011).

Data on violence against children are limited, and most countries depend on mortality data, developing child mortality statistics based on the International Classification of Diseases coding system. These mortality statistics are most useful for assessing child mortality and its main causes, but they do not provide information on details surrounding the deaths including social variables reflecting inequality and social disadvantage, and tend to underestimate deaths from violence and unintentional injuries (Schnitzer et al., 2008). According to some estimations, half of all deaths from child abuse are not recognised by the vital statistics (American Academy of Pediatrics, 2010).

In the late 1970s, Child Death Review (CDR) was initiated in the United States (US) with the revision of unexpected infant death as a way to ensure identification of cases of violence and neglect. CDR is a programme whose aim is to "conduct a comprehensive, multidisciplinary review of child deaths, to better understand how and why children die, and use the findings to take action that can prevent other deaths and improve the health and safety of children" (National Center for the Review & Prevention of Child Deaths, 2015). The objectives of CDR include the identification and reporting of the cause and manner of every child death, improving the communication among agencies involved in child protection at a national and local level, improving responses to child deaths, improving criminal investigation and prosecution of homicides, and identifying and advocating for needed changes in legislation, policy and practices and expanded efforts in child health and safety to prevent child deaths.

The main goal of CDR is doing justice to the victims by investigating the circumstances surrounding child fatalities, but it also aims to ensure that agencies and institutions responsible for child protection act appropriately to safeguard children by identifying situations where services can be improved. In addition, CDR can also play an important and critical preventive role by indicating what might be done to prevent future deaths in the community (American Academy of Pediatrics, 2010).

To further explore multidisciplinary child death review programmes across the European Union (EU), an in-depth investigation was included as part of the project 'Policy Investigation in Europe on Child Endangerment and Support (PIECES)'. PIECES is a two year initiative led and coordinated by the European Child Safety Alliance in partnership with experts in Austria, England, France, Lithuania, Romania and Spain, whose purpose is to conduct in-depth investigations of six policy areas in violence against children (VAC) in EU Member States provide a better understanding of how those policies are being implemented, monitored and evaluated with the intent of assisting in further defining good practice in the field (see Appendix 1 for a full description of the PIECES project).

This report presents a summary of findings from Policy area 5, which examined national policies, legislation, plans or strategies on violence against children, focusing on multidisciplinary child death review programmes across the EU.

Rationale and Objectives

Although a number of countries use some form of case review to assess fatal and/or serious child injuries, coordinated multidisciplinary national programmes, and specifically those with a focus on prevention, are much scarcer (Fraser et al., 2014; MacKay & Vincenten, 2012; 2014).

For almost two decades, the American Academy of Pediatrics has been encouraging CDR. More than half of the US sustains CDR committees reviewing deaths from all causes from birth to adolescence for public health purposes (American Academy of Pediatrics, 2010; Fraser et al., 2014). Multidisciplinary CRD is also included among evidence-based national policies to facilitate the prevention of child injuries and violence identified by the European Child Safety Alliance, but the implementation of national multidisciplinary CDR programmes in Europe is scarce (MacKay & Vincenten, 2012; 2014).

The main objectives of the research were:

- To identify experiences of implementation of national CDR polices in EU Member States
- To obtain data on the characteristics of CDR taking place in Europe
- To make recommendations to promote the implementation of CDR policies

Methods

Survey development

For the purposes of this investigation, we used the definition of CDR used by the National Center for the Review & Prevention of Child Deaths. The process of questionnaire development included several stages, beginning with a review of the literature around CDR and the development of an initial survey questionnaire by the lead author. The final questionnaire contains 26 questions (see Appendix 2 for the complete survey questionnaire) and includes items selected from published studies, covering different areas such as programme identification and structure, annual budget and activity, outcomes of the CDR process and impact on the community (Schnitzer et al., 2008; Fraser et al., 2014; Covington et al., 2015).

In the next phase the project team reviewed the survey questions until agreement was reached on the content, phrasing, and definitions. Special attention was devoted to eliminating duplication of issues by the members of the research consortium, while still covering the highest possible range of related aspects. The internal review process was followed by an external panel of either independent or public body experts in the area of violence against children from countries including Greece, the UK, and Canada, as well as from the European charter of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN). Following revisions, the survey questions were uploaded to a web-based survey platform in English only. The on-line survey and survey process were piloted in six countries (Austria, France, Lithuania, Romania, Spain and UK-England) and adjusted prior to contacting the remaining countries.

Respondents and survey process

Purposive snowball sampling was used to develop a database of potential respondents. All 28 EU member states plus Norway were included, and due to decentralisation of responsibility for aspects of policy related to VAC in the UK, attempts were made to complete a separate survey for England, Northern Ireland, Scotland and Wales (total n=32). Contact was first made with experts identified during a previous project examining violence against children (MacKay & Vincenten, 2014) and the WHO violence & injury prevention focal points in EU member states and appropriate respondents were sought. Additional were identified through PIECES project team member's professional networks and experts contacted also recommended alternate/additional respondents.

The data collection process involved identifying and contacting an expert within each country who could review the proposed list of respondents for all six policy areas including reporting and follow up, recommend alternate respondents if needed and assist in encouraging completion of the survey by those invited to participate. Following this an email inviting participation was then sent to each potential respondent along with a letter of support from the main funder – Directorate General of Justice and Consumers - and a web link and password to allow completion of the on-line survey. No incentive was provided to complete the questionnaire, however arrangements were also made to complete the surveys over the telephone in a few cases where there were technical or language difficulties. If the invited respondent was unable/unwilling to participate they were also asked to suggest alternate respondents. Invited respondents were contacted up to 10 times (minimum 3 contacts), prior to moving onto an alternate respondent. No ethics review was sought as no confidential information was gathered other than respondent identity and they were assured this would be kept confidential.

Data collection for the remaining countries initially took place over a 6-month period from May to October but was extended to January 2015 in an attempt to increase the response rate. Completed surveys were converted to an Excel spreadsheet and distributed to the lead author for review and analysis.

Data Analysis

Due to the small numbers of countries covered the scope for statistical analysis was limited and the analysis is mostly descriptive and thematic.

Results

Response

Key informants from 23 of the 32 (71%) countries targeted provided information on the existence of national CDR programmes. In 11 cases, the respondent contacted indicated there was no national programme and this was recorded without them completing the survey. For the remaining nine countries that did not respond or chose not to participate, previous studies conducted by the European Child Safety Alliance had confirmed that multidisciplinary CDR programmes were not implemented at a national level (Table 1) (MacKay & Vincenten, 2012; 2014)

Among the 23 country respondents, 14 (61%) were members of a government department, five (22%) were academics/senior practitioners and four (17%) were working in violence prevention or child protection focused NGOs.

Multi-disciplinary child death review

Only four respondents, Romania, Norway, Sweden and England (UK), reported the implementation of a national multidisciplinary CDR programme. The main results describing national multidisciplinary CDR programmes in these four countries are summarised in Table 2.

According to the responses of informants, Romania, Norway and Sweden have centralised CDR programmes, while in England, CDR is based on the work of local CDR teams. Four of the programmes (Norway, Sweden and England) were initiated within the last seven years, while in Romania CDR started over 15 years ago. Information on the annual budget of national CDR programmes was only reported for Sweden, with an annual budget of SEQ 1,000,000 (about 104,600 Euros).

In the four countries for which information was obtained, CDR has legislative, public health (preventive) and epidemiological objectives, and it is aimed at identifying violent deaths. In the case of England and Sweden, CDR also focuses on the evaluation of the functions of agencies involved in child protection and in Norway CDR contributes to the determination of cause of death and ensuring legal protection for both child and parent.

In all four CDR programmes, review committees include coroners or medical examiners and professionals from public health, and paediatrician or other family health provider, but the professional background of other team members varies from country to country. The CDR committee(s) meet once a year in Romania, four times a year in Sweden and more often in England and Norway (monthly and every time a new case is recorded).

All CDR committees use official reports as a source of information to perform reviews. In England and Norway information from interviews are also sources of information, although who is interviewed varies. All national CDR programmes publish at least an annual report, which in Romania and Sweden is intended primarily for government, while in the UK the report is also disseminated to local agencies involved in child protection. In Norway it is an internal report as the Norwegian Institute of Public Health (FHI) who is responsible for CDR is also responsible for acting on recommendations.

All four countries reporting indicated that the CDR review process specifically includes making prevention-related recommendations, with all but Sweden indicating that specific actions/changes have resulted from recommendations.

The connection between CDR teams and organisations involved in the prevention of violence against children was only reported in England. None of the respondents reported the existence of training programmes for CDR team members, although in Norway new members observe a few cases prior to being actively involved.

Table 1 – Implementation of national CDR programmes in EU28 plus Norway (n=32)*

Country	National CDR Programme
Austria	No
Belgium	No
Bulgaria	No
Croatia	No
Cyprus	No
Czech Republic	No†
Denmark	No
England	Yes
Estonia	No‡
Finland	No
France	No
Germany	No
Greece	No
Hungary	No national programme, but multiple committees examining different issues (e.g., perinatal deaths, intentional or injury related child deaths)†
Ireland	Child death reviews are only conducted in cases known to the Child Protection System†
Italy	No†
Latvia	No
Lithuania	No†
Luxembourg	No†
Malta	No†
Netherlands	Under development†
Northern Ireland	Yes
Norway	No
Poland	No
Portugal	No
Romania	Yes
Scotland	Yes
Slovakia	No
Slovenia	No
Spain	No
Sweden	Yes
Wales	Yes

*England, N. Ireland, Scotland and Wales contacted seperately for the UK

†Based on results of assessments for the 2014 Intentional Injury Report - accurate to July 2013 (MacKay & Vincenten, 2014

‡Based on results of assessments for 2012 Child Safety Report Cards - accurate to July 2011 (MacKay & Vincenten, 2012).

Table 2. National CDR programmes in Romania, Norway, Sweden and England (UK)

	Romania	Norway	Sweden	England (UK)
Organisation responsible for leading the CDR programme	Ministry of Health (Department of Mother and Child), UNICEF	Norwegian Institute of Public Health (FHI)	National Board of Health and Welfare	Local Safeguarding Children Boards
Programme initiation	1999	2010	2008	2008
Purpose of CRD	· Legislative · Public Health (prevention) · Epidemiology · Identification of violent deaths	· Legislative · Public Health (prevention) · Epidemiology · Identification of violent deaths · Contribute to the determination of cause of death · Ensure legal protection for both child and parent	· Legislative · Public Health (prevention) · Epidemiology · Identification of violent deaths · Evaluation of agency function	· Legislative · Public Health (prevention) · Epidemiology · Identification of violent deaths · Evaluation of agency function
Level of reviews	National	National	National	Local/municipal
Number of CDR committees operating	3	1	1	152
Composition of CDR teams	· Coroner / Medical examiner · Police / other law enforcement · Public Health · Child/safety advocacy (non governmental) · Paediatrician or other family health provider · Emergency Medical Services · Social services · Child protection services · Justice (criminal or family court systems, juvenile justice system)	· Coroner / Medical examiner · Public Health · Paediatrician or other family health provider · People with investigation skills (e.g., Police academy)	· Coroner / Medical examiner · Public Health · Mental Heath · Paediatrician or other family health provider · Emergency Medical Services · Social services	· Coroner / Medical examiner · Police / other law enforcement · Mental Heath · Paediatrician or other family health provider · Emergency Medical Services · Social services · Child protection services · Justice (criminal or family court systems, juvenile justice system) · Children and families
Frequency of CDR sessions	Annually	Every time a new case is reported	Four times a year	Monthly / Every time a new case is reported

	Romania	Norway	Sweden	England (UK)
Links between CDR team and those working in the area of violence against children	Don't know	No	No	Yes
Age range of children in the cases reviewed	0-4	0-4	0-18	0-17
Source of cases for review	· Coroner/medical examiner system · Death certificates/vital records · Child protection services	· Coroner/medical examiner system	· Prosecution authority or police authority	· Coroner/medical examiner system · Death certificates/vital records · Child protection services Suspected cases
Standardised form used for the identification process	Yes	Yes	Yes	No
Cases of child death reviewed	All causes of death	All unnatural causes of death with no suspicion of criminal activity	Deaths resulting from a crime, where the victim was in some kind of need of protection	Deaths where abuse/neglect is suspected; where there are doubts about whether have agencies have been effective in safeguarding the child
Average number of cases reviewed annually	2000	15	5 - 6	Don't know
Number of cases reviewed in 2012	1812	19	9	Don't know
Sources of information included in CDR process	· Birth certificates · Death certificates · Autopsy reports · Toxicological/laboratory tests · Social services reports · Child protection services reports · Data from other agencies	· Birth certificates · Medical records from hospitals and health centres · Autopsy reports · Toxicological/laboratory tests · Interviews with relatives	· Police records · Medical records from hospitals and health centres · Autopsy reports · Social services reports · Child protection services reports · Sentences from the Court of Justice	· Birth certificates · Death certificates · Police records · Medical records from hospitals and health centres · Autopsy reports · Toxicological/laboratory tests · Social services reports · Child protection services reports · Interviews (with relatives, professionals working with the child and/or family and other relevant actors) · Data from other agencies.

	Romania	Norway	Sweden	England (UK)
Training programmes for CDR team members	No	Informal - new members start off by observing a few cases first	No	Don't know
Average time spent between death and CDR	1 year	48 hours	1-2 years	< 1 year
Measures taken to guarantee data protection and confidentiality	Documents marked as "sensitive"	Don't know	-	Individual agencies, and potentially individuals may be identified. However, no information is included, the publication of which could cause potential harm to a child or vulnerable adult
Dissemination of results & recommendations	· Annual reports · Publications/reports following individual reviews · Press releases to media outlets · Media events · Papers in academic journals · Presentations in public forums	· Annual reports	· A report every second year	· Annual reports and a recent national repository of case reviews
Destination of reports	Ministry of Health sub-units	Norwegian Institute of Public Health (FHI)	The Swedish government	All local agencies relevant to the case/ensuring relevant improvements are made amd the National Children's Bureau
Review process specifically includes making prevention-related recommendations	Yes	Yes	Yes	Yes
Results of CDR have led to specific actions/changes	Yes	Yes	No	Yes

Discussion

Although the review of child deaths is one of the recommended policies to support efforts to reduce injuries and prevent violence against children, the implementation of such programmes in Europe is still very limited. The information provided by respondents indicates that, with the only probable exception of England, CDR committees currently operating in Europe appear to have limited local participation and face limitations in terms of the composition of review committees, the sources of information analysed, and the involvement of relevant agencies in implementing recommended actions.

National multidisciplinary CDR programmes have been implemented in a number of countries worldwide and are proving to be useful in identifying patterns of death, improving services and identifying preventative actions that can reduce the risk of similar deaths occurring in the future. In Europe, most EU Member States have not yet developed national or regional CDR programmes, a key national policy that should be considered. CDR programmes would not only improve knowledge of child mortality due to violence, but also those due to unintentional injuries and other causes. The knowledge produced is far more detailed than what is available through mortality statistics, and a focus on identifying modifiable factors related to child deaths can allow the development more effective prevention interventions. The dissemination of CDR national policies may be based on the experience of countries that have implemented CDR policies as well as the experiences of the many other countries already investigating suspicious deaths (Lang et al., 2010).

To identify most deaths caused by violence, CDR must be based on the use of data from multiple and varied sources of information, not only including existing reports and official documents, but also the testimony of people who know directly the circumstances of deaths investigated (Schitzer et al., 2008). National and international interpretation of the results of CDR requires the adoption of common definitions and coding systems not yet adopted in Europe (Schitzer et al., 2008).

CDR must put much emphasis on the evaluation of detected cases of violent deaths and propose solutions to prevent future deaths (Wirtz et al., 2011). The work of CDR teams must also include the ability to develop, write, disseminate and follow recommendations based on the results of the review process.9

The involvement of professionals from the public health sector and from other agencies involved in violence and injury prevention is essential, especially to ensure that the recommendations of CDR committees lead to the implementation of preventive actions. It may be also necessary to incorporate community and family members in CDR, especially at the stage of development and implementation of preventive recommendations (Sidebotham et al., 2011).

Limitations

The intent of this research project was to obtain answers from key respondents from all 27 EU MS (with England, N. Ireland, Scotland and Wales targeted separately in the UK) plus Norway. In general we have depended on the expertise of only one respondent regarding the existence of a multidisciplinary CDR programme. Thus, despite efforts to ensure the respondent was well positioned to knowledgably respond, the responses to some questions might have introduced some bias.

A second limitation with respect to describing the situation in the EU, concerns the 68% response rate. Experts in the rest of the countries invited to participate either did not respond, chose not to participate or committed to complete the survey but did not manage to fulfil that commitment. However we were able to find some information for those countries based on previous studies, so feel fairly confident the results represent the current situation with respect to national programmes.

A final important limitation was the definition of CDR used. We specifically looked at national multidisciplinary CDR programmes, although we did ask a secondary question regarding regional programmes. Many Member States have coronars systems that review 'all unnatural deaths' or severe case review programmes as part of child protection systems. For example, we have limited information on the programme in Northern Ireland (UK) or activities being undertaken in Greece, Hungary and the Netherlands. Had we asked for details about all CDR processes, it may be we would have a better idea of where countries are at, and how easily they could adopt and implement a national programme of multidisciplinary CDR.

Conclusions and recommendations

In order to improve child violence monitoring and to support prevention efforts, European countries should consider the introduction of multidisciplinary CDR programmes. At local level, the implementation of CDR teams can originate both in response to legal and political mandates or as community-driven initiatives. However, to ensure a positive impact of the CDR process on prevention activities, local CDR committees must be promoted, supported and coordinated at a national level.

From that point of view, the development of CDR programmes may be facilitated by seven measures (American Academy of Pediatrics, 2010):

1. Standardising the process of child death review
2. Providing standardised definitions for coding and structure for data collection
3. Providing training and technical assistance for CDR teams
4. Establishing criteria for quality improvement in data collection, evaluation and dissemination
5. Providing mechanisms to enable local and national data sharing
6. Establishing confidentiality and legal protocols
7. Publishing reports

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Appendix 1 – PIECES project description

PIECES – Policy Investigation in Europe on Child Endangerment and Support was a two year initiative led and coordinated by the European Child Safety Alliance (ECSA) in partnership with experts in Austria, England, France, Lithuania, Romania and Spain. The aim of the project was to conduct in-depth investigations of select policy issues in violence against children in the EU28 plus Norway, in order to provide a better understanding of how those policies are being implemented, monitored and evaluated. The intent was that the knowledge gained will assist in further defining good practice in the field of children and violence.

The target audience for the results are national and European governments and agencies who assess, set policy and invest in the prevention of violence against and by children as well as researchers in the field of child maltreatment, with the aim of ultimately preventing violence against all children in the EU with a focus on the most vulnerable children.

The project consisted of four steps:

- Development of a key informant list of those knowledgeable on the adoption, implementation and monitoring of policies to address violence against children in the EU28 plus Norway in order to ensure collection of valid detailed data on existing policies.
- Selection of 6 policies areas for more detailed study with the input of key informants to ensure those selected would have the most benefit to the field in Europe.
- Development and implementation of online surveys addressing the six policy areas selected to capture issues such as scope, target audiences, roles and responsibilities, infrastructure, barriers and enabling factors related to adoption, implementation and monitoring of policies including the level at which these activities/factors occur (national, regional, municipal, community, etc.).
- Analysis, synthesis and expert consultation on survey results and the identification of gaps, recommendations for good practice and issues to be considered when transferring polices to other Member States and priorities for further research.

Policy Areas explored

The six policy areas selected were:

1. Content analysis of existing national strategies addressing violence against children

   This investigation involved an in-depth look at existing national plans/strategies addressing violence against children to assess what was and was not covered. The investigation used a children's rights framework to explore the content of national strategies on VAC (covering key areas of provisions for primary prevention, protection, bringing justice, overcoming harm and child participation) and their implementation (the legal framework, system response, resources, capacity, coordination, cross sector working responsibilities). Informants were asked about the specific content of national strategies covering child maltreatment, violence against children in schools and communities, preventing child suicide.

2. Data sources on violence against children

   This investigation involved an in-depth exploration of existing routinely collected administrative data and periodic surveys in the area of violence against children, including suicide as a potential outcome of abuse.

3. Reporting and follow-up of violence against children

   This investigation explored in-depth the reporting mechanisms for violence against children and the processes for following-up reported cases.

4. Evidence-based violence against children prevention efforts related to building resilience in children and positive parenting

   This investigation involved an in-depth exploration of national home visitation programmes (both population-based and targeted programmes) and family support programmes (parenting programmes, etc.).

5. National Child Death Review Committees to inform policy and practice related to violence against children

   This investigation involved an in-depth look at national multi-disciplinary child death review committees to identify current practices and the benefits of these reviews for improving policy and practice for preventing and responding to violence against children.

6. National awareness activities on violence against children

   This investigation involved an in-depth look at national awareness raising activities related to violence against children.

Each of the six policy areas explored also looked at whether children were consulted on policy/programme development and implementation (child participation) and whether the issue of child poverty/inequalities was considered during policy/programme development, implementation or monitoring (child inequalities).

A summary report regarding the programme, working papers for the other individual policy areas and case studies of good examples of practice are available online at www.childsafetyeurope.org/PIECES.

Appendix 2 – Paper version of survey questionnaire

PIECES: Policy investigation in Europe on Child Endangerment & Support

In depth investigations - policy area #5: National Child Death Review Committees to inform policy and practice related to violence against children

Name of respondent:

Profession / speciality:

Organisation:

Position in organisation:

Address:

City:

Country:

Telephone:

E-mail address:

1. Does your country have a nationally coordinated programme of child death reviews - one or more multi-disciplinary standing committees/teams that use data from multiple sources to investigation unnatural deaths in children?
   If No…

   1.a. Does your country have one or more regionally coordinated programmes of child death review? If Yes…

      1.a.1 Do the different programmes make any effort to coordinate their activities (e.g., share process, use standardised forms, share results, etc.)?

      1.a.2 Do the regional programmes together represent national coverage of child death review?

      1.a.3 Which organisation is responsible for leading the child death review programme? (Fill in the blank)

2. Where is the child death review team housed (i.e. location and organisation)? (Fill in the blank)

3. Is there an annual budget for child death reviews? If Yes…

   3.a. What is their source of funding?What is their approximate annual budget? (Fill in the blank)

4. When did the programme of child death review begin? (Fill in year)

5. What is the purpose of child death reviews performed by the team?

- ❒ Legislative (including development and evaluation of laws, recommendations, enactments)
- ❒ Public health (including development and implementation of preventive policies and programmes – education, safety promotion)
- ❒ Contribution to epidemiological / research data (e.g., by identifying circumstances surrounding deaths)
- ❒ Specific identification of fatalities resulting from violence against children
- ❒ Evaluation of agency function
- ❒ Other (please specify) _____

6. At what level do the actual reviews take place?

- ❒ National
- ❒ Regional
- ❒ Local/municipal
- ❒ Other (please specify) _____

7. How many child death review committees are there?

8. Which of the following specialities are represented in the review team(s)?Coroner / Medical examiner

- ❒ Police / other law enforcement
- ❒ Public Health
- ❒ Mental Heath
- ❒ Child/safety advocacy (non governmental)
- ❒ Paediatrician or other family health provider
- ❒ Product safety
- ❒ Emergency Medical Services
- ❒ Social services
- ❒ Child protection services
- ❒ Justice (criminal or family court systems, juvenile justice system)
- ❒ Other (please specify) _____

9. How frequently does the review team meet?

- ❒ Every time a new case is reported
- ❒ Monthly
- ❒ Biannually
- ❒ Annually
- ❒ Other (please specify) _____

10. Are there specific links between the child death review team and those working in the area of violence against children?If yes…

10.a. Please briefly describe the links (e.g., who links, how it is accomplished, frequency, etc.)? (Fill in the blank)

11. What is the age range of children in the cases reviewed (e.g., ages 0-14, 0-18)? (Fill in the blank)

12. How are deaths identified for review?Coroner/medical examiner system

- ❒ Death certificates/vital records
- ❒ Child protection services
- ❒ Other (please specify) _____

13. Is there a standardised form used for the identification process? (Yes/No/Don't know)

14. What cases of child death are selected for review? (Tick all that apply)

- ❒ All causes of death
- ❒ A sample of all causes of death
- ❒ All unnatural causes of death
- ❒ A sample off all unnatural causes of death
- ❒ All intentional injury deaths
- ❒ A sample of all intentional injury deaths
- ❒ All unintentional (accidental) injury deaths
- ❒ A sample of all unintentional (accidental) injury deaths
- ❒ Other (please specify) _____

15. What is the average number of cases reviewed annually over the life of the programme? (Fill in the blank)

16. How many cases were reviewed in 2012? (Fill in the blank)

17. What sources of information are included as part of the child death review process?Birth certificates

- ❒ Death certificates
- ❒ Police records
- ❒ Medical records from hospitals and health centres
- ❒ Autopsy reports
- ❒ Toxicological/laboratory tests
- ❒ Social services reports
- ❒ Child protection services reports
- ❒ Interviews with relatives
- ❒ Interviews with professionals working with the child and/or family
- ❒ Interviews with other relevant actors
- ❒ Data from other agencies (please specify) _____
- ❒ Other sources (please specify) _____

18. Is there a standard form for the death review process (i.e., a form used to guide process and information captured)?If Yes…

    18.a. Is it possible to receive a copy of the form? (If yes see note at end of questionnaire regarding linking the document or sending a copy)

19. Are child death review teams given any specific training/preparation prior to undertaking child death reviews?If Yes…

    19.a. Who does the training?What does the training consist of (e.g., what topics are covered)?How many hours of training are received?Is the training standardised (i.e. is there a national curriculum)? (Yes/No/Don't know)

20. What is the average time span between death and review? (Fill in the blank)

21. Has the establishment of a programme of child death reviews resulted in any issues related to data protection?If yes…

    21.a. What are the issues and how have they been addressed?What measures are taken to guarantee data protection and confidentiality? (Fill in the blank)

22. Which of the following forms of dissemination are used to routinely share the results of child death reviews?Annual reports

- ❒ Publications/reports following individual reviews
- ❒ Press releases to media outlets
- ❒ Media events
- ❒ Papers in academic journals
- ❒ Presentations in public forums
- ❒ Anonymous data made available through electronic database
- ❒ Other (please specify) _____

23. To whom are results/reports of the review team routinely disseminated (e.g.,to what specific administrative/governmental bodies or what profile of professionals are reports sent)? (Fill in the blank)

24. Does the review process specifically include making recommendations (e.g., calling for a public awareness campaign, implementing a prevention programme, regulating the use of a product that has proven to be dangerous, etc.)?If yes…

    24.a. What proportion of cases have recommendations made as part of reporting?Is there any requirement that recommendations are acted upon?Are recommendations monitored to assess whether action is taken? (Yes/No/Don't know)

25. Have the results of child death reviews led to specific actions/changes in your country?If yes…

    25.a. Please give examples of types of action/change that has resulted from recommendations by child death review committee (Fill in the blank)

If you indicated there are standardised forms or annual reports please provide internet links here or send a copy by e-mail to m.mackay@childsafetyeurope.org or by postal mail to:

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Thank you for assisting us to better understand current practices with respect to child death review programmes across the European Union.


PIECES

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